Prevention of Mental Disorder

The Role of the General Practitioner

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■ *As prevention in psychiatry really refers to early detection and consequent prevention of complications and chronicity, the general practitioner is the most important person in the medical community in preventing mental disorders. As more postgraduate courses in psychiatry become available to practicing family physicians, the majority of patients with psychiatric disorders will be effectively managed by the general medical practitioner.*

The family physician is already doing this, although not as well as he could. In some instances, he may be unaware of the extent to which the disease with which he deals is psychic disease. As the number of community health centers increases, family physicians will play a vital role in their function. With the necessary knowledge to detect psychic disturbance and to treat emotional disorders effectively, the family physician will prevent many of the instances of progression to chronic psychiatric illness with which we are now plagued. The psychiatrist of the future will act as consultant, treating only patients with the more complicated mental disorders.

THE FAMILY PHYSICIAN is the nation's greatest resource for the prevention and recognition of emotional disturbance. He is also the major treatment resource for psychiatric illness. From a nation-wide interview survey by the Joint Commission on Mental Illness and Health, a nongovernmental multidisciplinary nonprofit organization representing a variety of national agencies concerned with mental health, it was reported in 1960 that 88 per cent of persons seeking help because they feared an impending "nervous breakdown" went to their family doctor. Only 4 per cent consulted a psychiatrist, while 3 per cent consulted clergymen.[5] In other words, the general practitioner is the overwhelming choice of people who seek help for psychiatric problems.

One might ask what the treatment of incipient mental disorder, felt by the patient as an approaching "nervous breakdown," has to do with the prevention of mental disorder. Since this communication is concerned with the role of the general practitioner in prevention, it is appropriate to define prevention as it relates to psychiatric illness. In this connection, it is proposed to distinguish between two types of prevention: one, the promotion of healthy personalities capable of withstanding normal stress; the other, the early detection of developing mental illness. This paper will concern both aspects of the prevention of mental disorder.

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The Concept of Prevention

Practically no one in psychiatry agrees with anyone else on how the healthy personality develops, or, indeed, on what constitutes a healthy personality. Most students in the field will agree to the rather broad statement that people are what they were to begin with, plus everything that happened to them after that. When it comes to assigning weight to the hereditary endowment, or the constitutional baseline, and to the various classes of events which occur after parturition, the general disagreement becomes manifest. It seems logical, though, that the relative importance of the many factors which act together to produce the final outcome of the personality, be it disordered or not, must vary in every instance. It seems equally logical, therefore, since little or nothing can be done, once birth has occurred, about modifying the hereditary or constitutional givens of the personality to direct prevention action toward the events, biological and interpersonal, that occur after the person is exposed to the world.

Susser and Watson[9] wrote: "The family is the reproductive nucleus of society, a fundamental social institution whose primary and essential task is to socialize 'the stream of new-born barbarians' so that they may take their place in life as mature and independent adults. From the moment a child is born the course of his physical and mental development is determined by his initial experiences within the family, and he can never free himself entirely from these early experiences. Every society, from nomads to city-dwellers, has the institution of marriage and stable family life. Through the family human beings maintain physical continuity by reproduction and maintain social and cultural continuity through training and education. The family regulates both the status and behaviour of the immature individual and controls his relations with other members of society."

The implications of the role of the family and of prevailing views on child-rearing are well illustrated in the following summary of Halliday's comments on differences between the child-rearing of many years ago and that of today (as quoted by Ewalt and Farnsworth[4]):

"Breast feeding was almost universal. In cases of difficulty, wet nurses were used. They were readily available, since about one infant in five died before reaching its first birthday. No special attention was paid to the length of breast feeding, and the occasions of suckling were determined by the desires of the child or the mother. This was facilitated by the prolonged body contact between them, since the baby was carried about by the mother in the folds of a shawl. Carriages were the prerogative of the wealthy. At night the infant might sleep in a wooden rocking cradle, but often it lay alongside its parents or siblings. Such a practice often led to death from 'overlaying,' especially if the parents were drunk, which was not rare in those days.

"Little bowel training was attempted until the second or third year. Infantile incontinence was of small moment to the generations who, before the introduction of water sanitation, possessed an easygoing tolerance of people's smells. Why worry? The child, given time, would naturally develop control of the sphincters and discover for himself the advantages of his unaided accomplishment. Floors were either stone or bare boarding, carpets being scarce and linoleum unknown. Furnishings were few but substantial; a table, a few wooden chairs or stools, and a straw bed often comprised all the furniture. The toddler had, therefore, a good deal of freedom, not only to defecate at his pleasure but also to explore and manipulate objects.

"The size of the family was large, children were plentiful, and juvenile nurses and playmates abounded. Toys were simple and few, and toddlers found natural pleasure in amusing themselves; hence, early social impulses found a ready fulfillment.

"Viewed physiologically, the child's environment was appallingly bad. Dirt, absence of pure water supply, inadequate sanitation, overcrowding, bad housing, poverty, malnutrition, and long working hours all contributed to tragically high rates of bodily impairments and death. Viewed psychologically, however, the child's environment was not so bad, for during the early years emotional growth was largely permitted to develop in its own way and in its own good time. The vital drives of the first and second phases obtained, therefore, a fair degree of outward expression; and it may be surmised that those physiologic dysfunctions and tensional states associated with the emotionally induced 'imbalance' of the vegetative nervous system were neither acutely provoked nor unduly prevalent. Only in the genital phase was there a great frustration of emotional growth; this took the form of ignoring the child, i.e., of seeing

him and not hearing him—a custom which, together with oedipal problems, may have a bearing on the apparently high incidence of hysteria in the Victorian era.

"Modern methods of child rearing have resulted in very great decreases in mortality and morbidity, but there are many rules and regulations, procedures to be followed, possible too-early bowel training, much emphasis on cleanliness, especially in view of the relatively abundant supply of household furnishings, carpets, bedding, etc. As a result of all the prohibitions, children have been set more and more against their parents, and the parents have felt that they are never let alone; the continuous reactive prohibitions and admonitions render the child inwardly insecure and outwardly difficult because of his inability to attain the orderliness, tidiness, punctuality, dutifulness, etc., demanded by the parents as a standard of behavior. Present-day life is apparently much more emotionally frustrating to children than that of the past."

Additional studies on the role of early family life in the development of personality and in the genesis of personality disorders can be found in the works of Spitz[8,9] and of Bowlby.[1] Observations made by Spitz on infants in foundling homes who were denied close physical contact with mothering persons, and comparing the outcome of their personalities with those who were not denied this close contact gave us important evidence that such closeness and warmth in mothering is crucial to the development of the child in a healthy direction both physically and psychologically. In fact, children who are totally denied such contact fail to develop at all. Bowlby studied the behavior of children who were removed from the mother-figures to whom they were attached and placed with strangers. He advanced the thesis that once the child has formed a tie to a mother-figure, which has ordinarily occurred by the middle of the first year, rupture of that tie leads to separation anxiety and grief and sets in train processes of mourning. He further observed that in the early years of life, those mourning processes not infrequently took a course unfavorable to future personality development and proposed that they predisposed to psychiatric illness.

Once the child is out of the cradle, his personality is influenced by an increasing number of relationships outside the family. In all of these, the ability of the family to represent a constant, stable and supportive force, while allowing the emerging individual to develop increasing independence from it, can make the difference between success or failure in the mastery of each successive stage of development. By the time the child reaches adolescence, if development has not been a healthy one, signs of personality disorder probably will be already in evidence. Since mental illness is a term now used to include everything from disturbances in one's way of dealing with others to major psychotic disorders, it is likely that the story has already been written by that time—mental illness, or mental health. Thus, prevention in the sense of averting the occurrence of mental disorder, must be closely related to the nature of the family life of an individual, whatever else it may be related to.

It should be emphasized, however, there are many variables in the formation of personality and in the production of mental illness. It is hard to know, therefore, whether or not even the most ideal family circumstances will necessarily prevent mental disorder. As a matter of fact, it is hard to define in our present state of knowledge exactly what "ideal" means when referring to family circumstances. There is some evidence that many things which at one time were considered to be deleterious to mental health and important in the production of mental illness, are actually not. For example, one study indicates that whether or not a mother works makes very little difference in the mental health of her children when they become adults. In fact, for the lowest and highest economic group, there is evidence that the children of mothers who work part-time had better mental health in adulthood than the children of non-working mothers.[7] The old notion about the effect of a broken home on mental health is now in question. A recent survey gives evidence that there is no greater risk of mental illness in a broken home than in one that remains unbroken, unless the remaining parent remarries.[7]

On the other hand, when one thinks of prevention as early detection of impending mental disorder, and instituting appropriate treatment to avert serious psychiatric illness, one is on a somewhat more solid footing. The signs of imminent psychiatric disorder are subtle but clear. They can be determined with reasonable accuracy and measures are now at hand which make it possible to take constructive action. If impending psychiatric illness is detected, and measures are taken to

preclude the necessity for treatment in a hospital, this is, indeed, prevention.

The Role of the General Practitioner in Prevention

The classical role of the family physician in our culture has been changing in recent years. During the fabled Golden Age of Medicine, which may have existed at the beginning of the Twentieth Century for about 10 or 15 years, the family physician was friend, advisor, councilor and even ex-officio member of many family councils. Today, with our careful division of the members of the family, the mother has her gynecologist, the children have their pediatrician, the older members of the family have their internist, and recently the elders have begun consulting their own geriatrician. Now there is evidence of the appearance of a new specialty to deal with adolescents. It is becoming rather difficult for any physician to deal with the family as a unit. Nonetheless, there are a few encouraging signs of a return to the concept of family practice. The specialist may once again resume his role as consultant called in for special situations by a family physician who retains primary responsibility for the health of the family unit. Viewed from the standpoint of preventing mental disorder, this is a more appropriate function for the specialist.

The counseling of a mother in child-rearing, helping her to learn to cope with her conflicts and frustrations in relation to her child, is a natural and spontaneous development of the medical relationship. Somatic disturbances, which often reflect an element of tension in her life, present the ideal circumstances for such counseling. That same family physician, with appropriate training and adequate perceptiveness, could most easily detect early signs of disturbance in the family milieu, as reflected in the behavior of the parents and the children. The father, who for some reason seems to be ignored in most discussions of mental health and who is ordinarily the most difficult to involve in family counseling when it is indicated, would be much easier to work with if he too consulted the same family physician.

It is conceivable that the family physician can in time become a true resource for the prevention of mental disorder in the classical sense of the word "prevention." Recent sociological studies of the functioning of the family unit in health and in disease, as well as its relationship to larger sociological units, are giving us information which can be directly applied by the physician who appreciates his role with the entire family. For example, physicians might well take active measures to change hospital policies which prevent parents from remaining with their children. The suggestion that the family physician concern himself with the functioning of the family unit assumes, of course, that he is willing to make himself acquainted with the available scientific information concerning family life. Continuing medical education programs now make such information available to family physicians.

There has been, however, a good deal of resistance by general practitioners to attending postgraduate courses and lectures given by psychiatrists on psychiatry in general practice. A recent course on "Sociology and the Family Doctor" offered to general practitioners in California had a total enrollment of 45 physicians out of 30,000 to whom brochures about the course were sent. This probably reflects a frequent complaint of many general practitioners that psychiatrists talk down to them and do not give them much useful information because they are afraid family physicians will either misunderstand or will attempt too much.[6] However, it may well be that enrollments for present continuing education programs in psychiatry are suffering from the errors of the past. There is considerable study going on now among postgraduate educators about the problem of defining teaching goals and developing teaching methods that will make psychiatric information available in useful form to practicing physicians. Psychiatrists hope to live down previous errors.

Early Detection and Early Treatment

As indicated previously, the majority of patients with psychiatric disorders consult their family physician first. The family physician also treats most of the patients with mental disorder, if we include all psychiatric complications of somatic illness and all psychiatric illnesses which are manifested by somatic complaints. Few, if any, patients with the possible exception of those in the upper-middle and upper socioeconomic classes, see the psychiatrist as a useful or practical source of help.[5] Many patients with somatically manifested psychiatric disorders recognize only the somatic manifestation itself. Even if it were possible to persuade every patient who had a psychological disorder to see a psychiatrist, this would be neither feasible nor de-

sirable. The appropriate resource for early detection and early treatment is the family physician. Where he is not doing an adequate job of managing those patients, it is only because of lack of the appropriate skills and knowledge.

Caplan[2] described a number of practical steps that the family physician can take in helping to prevent emotional disorder. He pointed out that in addition to his role in safeguarding healthy relationships, in giving direct help in crises and steering people away from maladaptive solutions to interpersonal problems, the physician has an important role in the psychiatric consultation itself. That is to say, his responsibility is not ended when he calls in a psychiatric consultant. "Mental health consultation is a joint collaborative endeavor," Caplan said, "and what I meant to imply is that it has to be a two-way process, in which not only the psychiatrist but also the physician must be an active partner. It is essential for the physician to realize that he must take active steps to educate the psychiatrist during these consultations so that he will understand the special nature of the management problems involved, which will be quite different from what he is used to in the very unusual circumstances of his psychiatric clinic or office practice. Working with the same psychiatrist over a period of time, the physician may be able to teach him enough about the daily problems of general practice and the life situations of ordinary people who do not consider themselves psychiatric patients that he can eventually get answers which come reasonably close to being useful, but he will usually have to work quite actively to take what the psychiatrist has to offer and to translate it for his own use."

It is not generally appreciated, either by psychiatrists or nonpsychiatrists, that most of what psychiatry has to offer in medicine consists of skills and techniques that are part of the everyday medical relationship. For example in the average course on physical diagnosis, the second year medical student is given a long check-list of information to be elicited from his patient. He is rarely taught anything about *how* to elicit it. Yet psychiatric educators are constantly refining interview techniques so as to favor the emergence of a maximum of spontaneous information and a clear picture of the patient's psychological discomforts and usual interpersonal behavior. Similarly, what we have learned about the role of communication in the alleviation of psychological discomforts is rarely brought out in courses relating to somatic disorder, although, of course, this is always emphasized in psychiatric courses.

The frequent separation of the psychiatric department from the remainder of the medical school or hospital contributes to a parallel compartmentalizing of the student's behavior toward patients. He learns one kind of behavior in the psychiatric department and a totally different kind in the rest of the medical curriculum. This splitting of his role persists into the practice years, and the average practitioner views "medical" behavior as separate and distinct from "psychiatric" behavior. One study reported that family physicians most often failed to diagnose psychotic conditions when these were accompanied by somatic complaints.[3] Yet with the effective integration of these two modes of behavior, the physician could effectively detect and deal with emotional disorders under the conditions, including time limits, imposed upon him by general medical practice.

Useful information about the newer psychopharmacological agents is available, yet rarely does it reach the family physician promptly. Far too often, the physician gets his information from the "detail man," who is essentially a salesman working for a pharmaceutical company, or from the striking and colorful advertisements in the medical journal, rather than from the articles and research reports in the body of the journal.

Unquestionably, need for treatment in a hospital can often be prevented through accurate diagnosis and early medication in the case of psychotic disorders. Equally often, prolonged psychiatric disability can be prevented by the appropriate diagnosis and interviewing techniques in patients who have minor somatic complaints of emotional origin. Similarly, patients with compensable injuries can be converted iatrogenically into chronic "compensation neurotics" by inappropriate handling.

A View of the Future

I am going to make an optimistic prediction, based on my conviction that the medical practitioner must come to play an increasingly important role in the prevention and treatment of mental disorders. I will predict that in the years to come, the medical student will be taught psychiatry in its appropriate context—the medical ward and the medical clinic—and not in the psychiatric hospital and the separate psychiatric clinic. I will predict

that the newer kind of medical interview behavior which will result will be further reenforced during internship, residency training and postgraduate medical education. Thus, new medical interviewing techniques will permit the physician to deal with the whole patient rather than with isolated organ systems.

The medical practitioner of the future will deal with the entire family, medically and psychologically, having at his command resources that include consultants in specialty practices such as psychiatry. The role of the psychiatric consultant, as that of other consultants, will be to advise the family practitioner when asked to do so, and to treat only patients with complicated psychiatric disorders that are too time-consuming for the circumstances of family medical practice.

Family physicians will play a vital role in the function of community mental health centers, both in knowing how and when to make referrals to such centers and in contributing time to the actual functioning of such centers. With the necessary knowledge of sociological and other behavioral sciences, he will become a force for mental health in the community. With the necessary knowledge of how to detect psychic disease and how to treat emotional disorders effectively, the family physician will prevent many of the instances of progression to chronic psychiatric illness with which we are now plagued.

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